PRIMARY CARE MODERNIZATION

Diverse Care Teams

CORE CAPABILITY

Create diverse care teams that are guided by the primary care provider in collaboration with the patient and family, integrate other professionals, coordinate with community supports, and promote the strengths of families and best health for all children.

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HOW CARE WILL IMPROVE

PATIENTS AND FAMILIES CAN...

- Ongoing support from a primary care team that is accessible in the doctor's office, at home, and in your community
- More time with your pediatric primary care provider when needed
- Behavioral health services right away in the pediatric office
- Help with childcare, nutritious food, transportation and other needs from a community health worker
- Connected to early intervention services from a navigator or care coordinator
- Help with school or childcare center from a care coordinator who knows your child's health needs
  - Fluoride treatment at the pediatric office to prevent cavities without having to go to a dentist

PEDIATRIC CARE TEAMS CAN...

- Enable PCPs to spend more time with patients and families and care teams to efficiently support the provider
- Expand capacity to support parenting, strengthen families and promote child well-being
- Improve coordination with schools, childcare centers, and other settings that playing a role in child health and development
- Expand PCPs' abilities to manage children with complex needs through tele-mentoring
- Improve access to language assistance and community supports to address family needs like housing, transportation and food security
- Improve practice efficiency, cultural effectiveness and care team satisfaction

PATIENT EXPERIENCE IN PRIMARY CARE MODERNIZATION

Jenny is almost three years old. Her parents are worried that she is not talking yet, and her daycare says she is being aggressive towards other kids. With full-time jobs and two more kids at home, her parents aren't sure how to help her.

Jenny's father takes time off work to take her to the doctor. They meet with her PCP, who recommends a developmental assessment and a home visit to understand Jenny's behavior. The visit is scheduled so that her parents don't miss work.

They meet with the social worker at the office who does a developmental screening. She refers them to a service near their house that supports children with developmental delays and has weekend hours.

The social worker visits Jenny's family at home to assess her behaviors. She visits her at daycare to learn more about her aggressive behaviors. She works with Jenny's primary care provider and her parents to develop a care plan.

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HOW

Care Team and Network Requirements

- Hire care team members to provide functions defined by the American Academy of Pediatrics, including: well visits and preventive care; acute and chronic care; care management; care coordination; patient navigation; behavioral health integration; oral health integration; and chronic illness self-management
- Deploy care team members in the practice, in the community or patient homes, and/or at a network central hub
- Coordinate with community services and other places where patients receive care (e.g. schools, childcare centers)
- Utilize Community Health Workers to link patients and families to culturally appropriate community resources, track follow-up, and provide support
- Ensure care team members apply their skills to the top of their training
- Train team members to deliver effective team-based care, including workflows and communications
- Provide access to tele-mentoring programs for care teams (e.g. Project ECHO) in collaboration with community-based organizations to expand ability to manage more complex cases

Health Information Technology Requirements

- Access to common electronic health record (EHR) platform for all care team members
- Analytic resources to identify populations at risk, develop, implement and refine operations and to support continuous health promotion and quality improvement
- EHR and protocols to ensure capture of all interactions between patient and care team members, including non-office-based care
- EHR supports population and registry management and care management
- EHR includes a comprehensive care plan with role-based care team access
- Data sharing systems between practices, community care settings (e.g. school health centers), and centralized care coordination resources when possible

MEASURING IMPACT

✓ Patient Experience

- Improved patient and family experience through more timely, culturally effective, coordinated, and family-centered care, including behavioral health care; increased community and provider support for stress and worries

★ Quality

- Increased screenings and follow-up (e.g. oral screenings, developmental assessments)
- Improved preventive and well-child care
- Improved health promotion outcomes (e.g. school readiness, healthy weight)
- Improved chronic illness outcomes (e.g. asthma, childhood obesity)
- Reduced risk for development of chronic conditions in adulthood

$ Cost

- Lower out of pocket costs for services in primary care and by non-billable team members
- Reduced healthcare costs over lifetime by identifying and preventing risks in childhood

Access

- Easier access to services including behavioral and oral health, in the practice, home, or community
- Assistance accessing culturally appropriate medical services and community supports

IMPROVING HEALTH EQUITY

Health disparities, such as those faced by communities of color or non-English speakers, start early in life. They can be reduced in part by pediatric care that identifies and address health and social determinant risks early. Care teams can help by:

- ✓ **Having community health workers who reflect the family's community and culture** and medical interpreters who address language barriers.
- ✓ **Linking families to childcare, nutrition services, developmental supports** and other community resources.
- ✓ **Using peers to provide culturally appropriate support** to families, such as parenting support.

LEARN MORE!
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PEDIATRIC DIVERSE CARE TEAMS

Supports Child Health Promotion and Well-Being to Achieve Vision of Pediatric Primary Care

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